DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-22565 (09/2019)

STATE OF WISCONSIN

AUTHORIZATION FOR RECOUPMENT CARETAKER SUPPLEMENT (CTS)

Instructions: Complete and fax to 608-221-0991 (EDS).

Completion of this form is required under the provisions of Wis. Stat. § 49.775. Failure to comply may result in a denial of recoupment. Personally identifiable information on this form will only be used to obtain relevant data required.

*The provision of your Social Security Number is mandatory under Wisconsin Statutes. Your Social Security Number will be used to verify whether you receive SSI and to make certain that your SSI Caretaker Supplement benefits are paid to the correct person. If you do not provide your Social Security Number, your SSI Caretaker Supplement benefits will be denied.

ES Worker Name	FAX Number ( )	Telephone Number ( )
Caretaker Name	Caretaker Social Security Number*	
Caretaker CARES Case Number	Total Recoupment Dollar Amount $	

Date the Caretaker Supplement Overpayment was discovered by the ES Worker (mm/dd/yyyy)

Itemized Recoupment by Month

Month / Year	Amount	Reason

Date - Case Comments on CARES (Authorizations without comments on CARES will be returned.) (mm/dd/yyyy)	Date - Notice of Recoupment Faxed to EDS (mm/dd/yyyy)

SIGNATURE - ES Worker	Date Signed (mm/dd/yyyy)
SIGNATURE – Supervisor	Date Signed (mm/dd/yyyy)

For EDS Use Only

Date Keyed _____

Date Returned _____